Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Copley Memorial Hospital	Medicare Provider Number: 14-0029
Street: 2000 Ogden Ave	Medicaid Provider Number: 1007
City: Aurora / State: Illinois	Zip: 60504
Period Covered by Statement: From: 07/01/2007	To: 06/30/2008

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
XXXX	Corporation		Partnership		City		Hospital District
	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

XXXX	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation		Other (Specify)

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

XXXX	Medicaid Hospital		Medicaid Sub II		DHS - Office of Rehabilitation Services
	Medicaid Sub I		Medicaid Sub III		U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Copley Memorial Hospital 1007 for the cost report beginning 07/01/2007 and ending 06/30/2008 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):	Signed (Officer or Administrator of Provider(s)):
Name (Typewritten)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	144	52,704		39,339	74.64%		12,665	3.55
2.	Rehab	18	6,588		3,925	59.58%		427	9.19
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	12	4,392		3,307	75.30%			
6.	Coronary Care Unit								
7.	NICU	9	3,294		2,336	70.92%			
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	24	8,784		9,346	106.40%			
22.	**Total**	**207**	**75,762**		**58,253**	**76.89%**		**13,092**	**3.74**
23.	Observation Bed Days				2,558				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				7,089			4,771	1.78
2.	Rehab								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				254				
6.	Coronary Care Unit								
7.	NICU				1,143				
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				2,912				
22.	**Total**				**11,398**	**19.57%**		**4,771**	**1.78**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	25,425,878	120,393,586	0.211190	5,257,329		1,110,295	
2.	Recovery Room	1,489,312	9,251,304	0.160984	441,173		71,022	
3.	Delivery and Labor Room	8,388,485	32,923,915	0.254784				
4.	Anesthesiology	1,105,942	10,744,181	0.102934	1,215,685		125,135	
5.	Radiology - Diagnostic	18,399,704	128,491,332	0.143198	3,423,114		490,183	
6.	Radiology - Therapeutic	4,844,525	24,888,015	0.194653	53,157		10,347	
7.	Nuclear Medicine							
8.	Laboratory	11,998,440	112,317,412	0.106826	8,012,122		855,903	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,227,733	23,444,625	0.137675	3,495,210		481,203	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,910,067	13,412,545	0.142409	554,845		79,015	
17.	EEG							
18.	Med. / Surg. Supplies	1,184,316	31,212,405	0.037944	5,211,980		197,763	
19.	Drugs Charged to Patients	20,518,802	119,312,306	0.171976	8,852,717		1,522,455	
20.	Renal Dialysis	761,448	2,289,265	0.332617	177,176		58,932	
21.	Ambulance							
22.	Day Surgery	3,174,431	9,193,888	0.345276	64,650		22,322	
23.	GI Lab	1,776,661	9,921,364	0.179074	258,272		46,250	
24.	Rehab Services	3,483,648	15,736,390	0.221375	684,979		151,637	
25.	CV Surgery	3,965,612	7,930,063	0.500073	281,446		140,744	
26.	Vascular Services	10,086,410	43,779,000	0.230394	1,862,480		429,104	
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	914,108	7,407,725	0.123399	38,531		4,755	
44.	Emergency	13,331,025	64,031,783	0.208194	1,166,785		242,918	
45.	Observation	2,294,398	3,539,002	0.648318				
46.	**Total**				**41,051,651**		**6,039,983**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Rehab	Sub II Sub II	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	37,579,470	2,875,432		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	41,897	3,925		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	896.95	732.59		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	7,089			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,358,479			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cost (Line 3 + Line 6)	6,358,479			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	5,669,864	3,307	1,714.50	254	435,483
9.	Coronary Care Unit					
10.	NICU	7,510,023	2,336	3,214.91	1,143	3,674,642
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,097,150	9,346	224.39	2,912	653,424
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					6,039,983
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**17,162,011**

Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Rehab						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	NICU						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	**Total (Sum of Lines 22 and 26)**								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room	584,608	32,923,915	0.017756				
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Day Surgery							
23.	GI Lab							
24.	Rehab Services							
25.	CV Surgery							
26.	Vascular Services	15,240	43,779,000	0.000348	1,862,480		648	
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	16,185	7,407,725	0.002185	38,531		84	
44.	Emergency	173,347	64,031,783	0.002707	1,166,785		3,158	
45.	Observation							
46.	**Ancillary Total**						**3,890**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics							
48.	Rehab							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	73,805	3,307	22.32	254		5,669	
52.	Coronary Care Unit							
53.	NICU							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**5,669**	
68.	**Ancillary Total (from line 46)**						**3,890**	
69.	**Total (Lines 67-68)**						**9,559**	

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Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0029	1007
Program: Medicaid-Hospital	**Period Covered by Statement:** From: 07/01/2007 To: 06/30/2008

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	17,162,011	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)	9,559	
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	312,869	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**17,484,439**	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	41,051,651	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	21,809,917	
	B. Rehab		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	597,225	
	F. Coronary Care Unit		
	G. NICU	8,750,153	
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	159,095	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	72,368,041	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		54,883,602
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	17,484,439	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	17,484,439	
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With CMS Pub. 15-II, Sec. 115.2 (B)		
6.	**Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)**	**17,484,439**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	**Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)**		

* Line 9 DOES NOT APPLY to the Medicaid program.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	54,883,602
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	**Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)**					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	**Total (Sum of Lines 1 - 3)**					

Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1.	Physicians on hospital staff average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3.	Total Per Diem (Line 1 Plus Line 2)	

	Part B. Program Data	General Service	Sub I Rehab	Sub II Sub II	Sub III Sub III
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	General Service	Sub I Rehab	Sub II Sub II	Sub III Sub III
7.	Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8.	Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

		Adults and Pediatrics	Sub I Rehab	Sub II Sub II	Sub III Sub III
1.	Gross Routine Revenues				
	(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)				
	(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)				
	(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)				
6.	**Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))**				
7.	Private room cost differential adjustment (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552, W/S D-1, Part I, Line 37)				
9.	**Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1)**				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	147,555	120,393,586	0.001226	5,257,329		6,445	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	74,689	128,491,332	0.000581	3,423,114		1,989	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Day Surgery							
23.	GI Lab							
24.	Rehab Services							
25.	CV Surgery	137,232	7,930,063	0.017305	281,446		4,870	
26.	Vascular Services							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	130,553	7,407,725	0.017624	38,531		679	
44.	Emergency	129,339	64,031,783	0.002020	1,166,785		2,357	
45.	Observation							
46.	**Ancillary Total**						**16,340**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics	1,718,442	41,897	41.02	7,089		290,791	
48.	Rehab	202,206	3,925	51.52				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	74,689	3,307	22.59	254		5,738	
52.	Coronary Care Unit							
53.	NICU							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**296,529**	
68.	**Ancillary Total (from line 46)**						**16,340**	
69.	**Total (Lines 67-68)**						**312,869**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0029	1007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2007 To: 06/30/2008

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,486		8,486
Newborn Days	2,912		2,912
Total Inpatient Revenue	72,368,041		72,368,041
Ancillary Revenue	41,051,651		41,051,651
Routine Revenue	31,316,390		31,316,390
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes: